Intimate partner violence and HIV: clearing up confusion

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On Nov 25 every year, the International Day for the Elimination of Violence Against Women, and the 16 days of activism that follow it, help to draw the world's attention to the scourge of intimate partner violence and other forms of gender-based violence and their harmful effects on women's health, families, and communities. Related to this event, Dick Durevall and Annika Lindskog's report in *The Lancet Global Health*[1] is very timely. It not only provides key evidence about the positive association between intimate partner violence and HIV across sub-Saharan African countries but also moves intimate partner violence research forward in several important ways.

First, Durevall and Lindskog's use of a clean comparison group is a simple, yet important, methodological innovation in the study of intimate partner violence. Researchers have long recognised that many types of intimate partner violence exist and that these are not mutually exclusive, yet few analyses have accounted for the confounding effects of this multidimensionality. Durevall and Lindskog's use of a control group comprising only women who have not experienced any intimate partner violence at all—rather than the more frequently used control of women who have not experienced the form of intimate partner violence whose effect is being sought—makes the methodological leap of eliminating the so-called noise associated with a control group that contains other overlapping dimensions of intimate partner violence. This approach is an important innovation, notwithstanding the fact that how clean the comparison group is depends on both the coverage of all possible forms of intimate partner violence and on accurate reporting by women.

Another important contribution from this report is the finding that intimate partner violence is most consistently related to women's HIV-positive status when it is combined with male controlling behaviours. This result emphasises the role of the context of intimate partner violence—especially whether the violence is part of a syndrome of perpetrator-related behaviours—in establishing the effect of intimate partner violence on health outcomes. Durevall and Lindskog suggest that the joint experience of male controlling behaviours and violence is probably a proxy for controlling coercive violence and helps to distinguish it from situational couple violence.[1] This distinction mirrors the Johnson and Ferraro[2] categorisation of intimate partner violence as common couple violence or intimate terrorism, in which common couple violence tends to be reciprocal, a result of argument escalation, and less likely to be associated with an intent to control, whereas intimate terrorism embodies a pattern of behaviour aimed at controlling and terrorising. Although male controlling behaviour probably captures some aspect of coercive violence, it is unlikely to be a good proxy in all cases. To this end, The Demographic and Health Surveys Program has recently added a question about fear of the partner in its domestic violence module in order to add to the set of variables that can be used to distinguish between different types of intimate partner violence.

The current report also confirms, once and for all, the idea that even in cross-sectional household-based Demographic and Health Survey data, women who experience intimate partner violence have an increased risk of being HIV positive. When Harling and colleagues'[3] article was first published in 2010, the equivalent of a shocked silence fell across the gender-based violence community. The study had found no significant association between women's HIV status and their experience of intimate partner violence in all of the sub-Saharan African and three other countries for which Demographic and Health Survey data were available. The timing of publication of the report could not have been worse. Despite strong evidence of the negative effects of intimate partner violence on several aspects of women's reproductive health, it was not until intimate partner violence was judged to be a risk factor for HIV that the gender-based violence community had finally gained traction in obtaining international commitment for the elimination of intimate partner violence. In fact, it was during this period that the community had finally been able to propose to the UNAIDS-led HIV Monitoring and Evaluation Reference Group that intimate partner violence in the past 12 months become the UN General Assembly Special Sessions indicator to monitor the goal of gender inequality reduction. Although the proposed indicator was finally accepted,[4] Harling and colleagues' report had very nearly derailed these efforts. However, until Durevall and Lindskog's analysis, it had remained a mystery as to why the association between

intimate partner violence and HIV that was so evident in cohort studies (eg, Jewkes' and colleagues 2010 paper[5]) and in special populations (eg, the report by Maman and colleagues[6]) was not consistently evident in Demographic and Health Survey data. For this connection, Durevall and Lindskog's analysis of the relation between intimate partner violence and HIV by HIV prevalence also provides meaningful insight.

Although this article and others that provide evidence of a strong association between intimate partner violence and sexually transmitted infections[7] are crucial to focusing attention on the importance of intimate partner violence elimination, what is less understood is the "why" behind these associations and the direction of causality. For HIV infection to spread from one partner to another, infection needs to enter the relationship and it has to be communicated. Sexual violence—the one direct pathway for HIV infection to pass between partners—has rarely been shown to be strongly associated with HIV status. Other explanations are needed.

Durevall and Lindskog's study has many strengths, but it does not escape a weakness common to many studies that use Demographic and Health Survey data—namely, a failure to check back to the questionnaires for every survey included in the analysis. For example, researchers often fail to recognise that never-partnered or never-married women are eligible for the Demographic and Health Survey domestic violence module in most surveys but, because of their never-partnered status, are ineligible for the questions about spousal violence; similarly, the Durevall and Lindskog report also does not account for the fact that, in the 2005 Rwanda Demographic and Health Survey, widowed women, although few in number, were not asked the spousal violence questions. Although The Demographic and Health Survey Program strives to standardise its questions and its approaches across countries, both questions and approaches must respond to host country needs and can change over time. Hence, researchers using Demographic and Health Survey data need to check the questionnaires to make sure they understand exactly what was asked and who is included in the sample.

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4 UNAIDS. Global AIDS response progress reporting 2012. Guidelines: construction of core indicators for monitoring the 2011 political declaration on HIV/AIDS 2012 reporting. Geneva: UNAIDS, 2011. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf (accessed Nov 25, 2014).
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7 Kishor S. Married women's risk of STIs in developing countries: the role of intimate partner violence and partner's infection status. *Violence Against Women* 2012; **18:** 829–53.